Name:_____ ØBUS P Nr: _____

(do not fill out)

Do you daily or almost daily ingest

	Yes	No	How Long		Drug name
Hjertemagnyl/ Magnyl/ Codymagnyl/Acetylsalicylsyre	☐	☐		years	
Bloodpressure pills	☐	☐		years	
" (more)	☐	☐		years	
" (more)	☐	☐		years	
Heart medication	☐	☐		years	
" (more)	☐	☐		years	
" (more)	☐	☐		years	
Diuretics (water tablets)	☐	☐		years	
Medication against high cholesterol	☐	☐		years	
Pills for arthritis	☐	☐		years	
Sleeping pills	☐	☐		years	
Sedatives or pills for depression	☐	☐		years	
Pills for acidity or acid reflux	☐	☐		years	
Medication for asthma/bronchitis Spray/inhaler)	☐	☐		years	
Insulin	☐	☐		years	
Other medication for diabetes	☐	☐		years	
Contraceptive pills	☐	☐		years	
Hormon supplemnts for menopause	☐	☐		years	
Pills/drops for eye disease	☐	☐		years	
Painkillers or pain relieving medicine	☐	☐		years	
Weight-loss/anti-obesity pills	☐	☐		years	
Other medication	☐	☐		years	
Vitamine pills	☐	☐		years	
Herbal medicine/Dietary supplements	☐	☐		years	
Herbal medicine/Dietary supplements	☐	☐		years	
Herbal medicine/Dietary supplements	☐	☐		years	

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